University of Colorado
Anschutz Medical Campus

Department of Pediatrics
Prevention Research Center for Family and Child Health
Mail Stop 8410
13121 East 17th Avenue
Aurora, Colorado 80045

Nurse-Family Partnership® (NFP) International

Guidance Document - National Requirements for Implementing Nurse-Family Partnership | March 2019

1. Introduction

It is almost 15 years since University of Colorado (UCD) began replicating Nurse-Family Partnership (NFP) internationally and during this time we have learnt a lot about what is needed at a national [1] level to ensure successful replication within a country. We thought that it would be useful to pull this learning together, with the relevant research and experience from the US National Service Office (NSO), to guide new and existing partners as they set up and develop their National Implementation team or National Unit as it is referred to in some countries [2].

This guidance sets out the functional requirements that UCD expects license holders to include in their implementation team and suggests ways of quality assuring these functions. This guidance will need to be adapted to reflect the context, stage and scale of the program in each country/province and, of course, there is still much to be learned. A new country in the Adaptation Phase (Phase One)[3] of replication will have different needs from a country that is in the Randomized Controlled Trial (RCT) Phase (Phase Three).

The evidence

The literature on implementing evidence based programs stresses the importance of having an 'Implementation Team' to ensure successful replication[i]. It is estimated that using implementation teams produces higher rates of implementation success (80%) than without (14%)[ii]. The team is accountable for 'making it happen' by providing the structure to move the programme through the stages of replication i.e. to establish, adapt, maintain, replicate, quality improve and disseminate NFP in real world settings.

Successful implementation teams are more likely to have the following characteristics[iiiiv]:

- Collectively have the knowledge, skills, abilities and time to succeed.
- To be focused on using data to monitor and improving programme quality locally
- To be flexible and responsive to the needs of government and local implementation partners
- To be sufficiently agile to quickly identify and adapt to new challenges

[1] In some large countries the 'province' or 'territory' may be the right level for the implementation team
[2] The term 'National Implementation Team' (NIT) or National Unit is used here to describe the group of people responsible for replicating NFP in a country from Phase 1 to Phase 4
[3] See Annex 1 for description of NFP international replication phases

- Core competencies of:
    - knowledge and understanding of core program components and linkages to outcomes
    - knowledge of implementation science and recommended practice for implementation
    - appreciation of the local ecology and its impact on program implementation
    - applied experience in using data for program improvement and continuous quality improvement

2. Principles of implementing NFP at a national level

In NFP some implementation functions may be spread across different organisations. For example, UCD leads on program augmentation and developments, while in some countries the license holder is different from the implementation team and for some the education program is provided externally. Regardless of international variations a common set of principles underpins successful implementation at a national level.

- Clinical leadership: NFP is a clinical program and replication with fidelity requires an expert clinician/s in lead role/s in the implementation team for every phase of replication.
- Functional integration: all the functions are interdependent and work better if they are all in one organisation and setting. For example, quality improvement relies on the information system, service development and clinical functions all working together and learning from each other
- Sustainability: long term program sustainability can be a challenge when resources are scarce. A key task of a national implementation team is to secure the future of NFP, ideally from the beginning, through policy support, funding and local commitment
- Forward planning: teams need to build their capacity and systems in preparation for the next phase of replication and expansion, such as capacity for nurse education, system design, supporting new sites, infrastructure and managing additional data from more clients and nurses
- Multi-level alignment and commitment: Reflecting the values, methods, outcomes and behaviours of NFP throughout the implementation system brings coherence and supports nurses in their work with clients
- Client involvement: Engaging clients during each phase of replication so that they are involved in quality assuring and shaping NFP nationally and locally
- Continuous development: NFP is a work in progress and is continually being developed and improved.
- Research minded: Each new country has to find out whether NFP works in their setting and the impact for children and families. This requires a commitment to on-going evaluation
- Dedicated implementation team: It helps to have a discrete NFP unit with dedicated NFP implementation experts working together who can develop their skills and focus on testing, embedding and sustaining the program well in their context
- Accountability: The implementation team needs a clear line of accountability to the license holder for meeting the NFP licensing and quality standards

- Business support: NFP is a complex program to lead and implement requiring sufficient business and administration capacity within the team

3. Responsibilities of the national implementation team:

The following functions may be shared amongst the team, and individuals may take on more than one function. The number of people needed within the team may only be two or three during phases 1 and 2 and will need to be increased according to the scale of implementation.

a. Continuous quality improvement

The quality standards for NFP are set within the core model elements and fidelity benchmarks. Each country may have its own additional quality measures relevant to their context. At a national level this function includes:

- A process for monitoring and assessing quality of program implementation against these standards
- A process for supporting local implementing organisations, nurses and supervisors in continuous quality improvement
- Systems for engaging clinical teams, organisations, communities/clients and national stakeholders in quality improvement
- Systematically identifying ways in which NFP can be developed and improved
- Completing the annual report for UCD and participating in the annual review meeting(? add link to new guidance)
- Evaluating the quality of the work of the NIT

b. Clinical leadership, education and coaching

NFP is a clinical program serving some of the most vulnerable children and families in a country. It is complex and demanding to deliver and nurses need to learn and practice in new ways. The clinical function is the core responsibility of any NIT and needs to be reflected in resources and structures. The function includes:

- Ensuring that nurses and supervisors receive the education and coaching that they need to become competent to deliver the program and that builds on their pre-existing professional education and experience. The system, content and methods of education and coaching need to prepare registered nurses and supervisors in the unique practice skills inherent in relationship-based, strengths-focused intervention and be relevant to local context.
- Clinical governance responsibility so that NFP reflects best practice within each country on issues such as child protection, child and maternal health clinical practice and professional regulation
- Providing on-going opportunities for reflection, problem solving and learning through a community of practice
- Ensuring a system is in place for on-going clinical consultation and reflective supervision/ coaching (for supervisors and nurses) on practice issues as they relate to the NFP model.

- Adapting visit-to-visit guidelines and materials for the country being served by NFP and over time in relation to new maternal or child health research evidence
- Aligning and embedding NFP nursing practice and education within national systems of accreditation, service provision, professional regulation, governance and education
- Developing capacity for self-sufficiency and sustainability in education and coaching as the program grows, if viable option, and moves beyond Pilot Testing Phase (Phase Two)
- Implementing new program augmentations as they are developed, amended as required for local context

c. Service development and organisational support

Successful local implementation depends on the commitment, understanding and capacity of local agencies and communities. The NIT supports local agencies through systems and processes for:

- Assessing local readiness to implement NFP
- Preparation and planning in local areas
- On-going support on managing the program within the local context
- Local quality improvement
- Establishing local community advisory boards
- Sustainability of the local program.
- Organisational and leadership development for implementing agencies
- Ensuring that NFP is embedded within local services for children and families

d. Information monitoring and analysis

The NIT team needs a system for monitoring program fidelity. This function includes:

- Commissioning and/or managing an information system (which ideally includes an e-documentation system) with the capacity to collect and analyse the data needed for high quality program replication and as required by UCD for monitoring the program and completing the annual report.
- Minimising the administrative burden on nurses
- Producing valid and reliable reports that are meaningful to nurses and supervisors, and enable comparison between areas
- Assisting sites to develop the skills necessary to analyse data for their own service provision enhancement
- Monitoring national and individual site data and engagement with implementing agencies regarding local progress against fidelity goals, to ensure that quality improvement issues are identified, and actions plans to develop these are progressed.
- Analysing trends, emerging patterns, local variations and anomalies in national data and undertaking further analytical work to draw conclusions, using this learning to establish additional, themed, quality improvement work, as necessary

e. Research

Each country needs to start without any assumptions that NFP will work in their country and commit to evaluating the program. As part of the license each country needs to commit to evaluation of the testing phase followed by a large scale research trial. This function includes:

- Developing a national research strategy and oversee the NFP research program
- Commissioning and supporting the formative evaluation of NFP in Phase Two and the RCT in Phase Three
- Planning and implementing Phase Four (replication) assuming positive outcomes of RCT
- Identifying areas for research from NFP information system and via learning from the communities of practice
- Establishing relationships with research leaders in their country
- Collaborating with the PRC team at UCD to develop and test programme augmentations
- Collaborating with local/national researchers to support further national evaluation of the NFP
- Contributing to an international forum identifying international research priorities for NFP and working collaboratively with NITs on new research projects

f. Strategic leadership and policy

We have learnt that government commitment and policy support for NFP is essential for sustainability and resourcing the program and we expect the Government to act as the license holder. The NIT needs to:

- Create and communicate the vision and strategic plan for NFP in their country
- Work with Government to promote maternal and child health evidence based programs and support best use of funds
- Ensure broad based, bi-partisan policy support for NFP, its principles, practices and implementation requirements
- Secure sustainable financing and workforce development for NFP
- Secure sustainable funding for the NIT and be assured of its clinical efficiency and cost effectiveness

g. System and community integration

To fit NFP within the country's wider child and maternal health services and professional context the team needs to:

- Build collaborative relationships and share learning with child health experts and leaders
- Establish a national advisory group to bring in additional expertise and involve key players in the development of NFP in their country
- Participate in national policy, professional and practice developments
- Secure the NFP implementation team's position and reputation within national context

- Communicate to increase public awareness and increase visibility of the program at the local and national levels.
- Provide materials to other agencies and stakeholders to increase understanding of NFP
- Share learning from NFP Implementation and be receptive to wider learning from aligned practitioners working with children and families

4. Quality assurance of the work of the national implementation team

NFP implementation teams will wish to develop their own systems for reflecting on how well they are doing. The following are some suggested ways of doing this:

a. Monitoring the quality of program replication through NFP information system
b. The UCD annual report which reviews the quality of replication and national implementation functions as part of the licensing process
c. The formative evaluation and RCT
d. Feedback from stakeholders who experience the services provided by the team, e.g. local leaders and other agencies, NFP supervisors and nurses
e. On-going and one-off evaluations of specific aspects of implementation work to assess impact, acceptability, cost-effectiveness and relevance to local context of the:
    - Education program
    - Coaching system
    - Service development
    - Information system
f. In-depth analysis of major program incidents such as maternal and child deaths
g. Assessing NIT competencies through team and individual reviews (see 6)

5. Competencies needed within the national team

Clinical Expertise[4]:

- Clinical credibility and authority within the profession of nursing
- Deep understanding of the NFP and how nursing practice achieves the outcomes
- Models the values and methods of NFP
- Understands continuous quality improvement
- Adult learning methods
- Curriculum development
- Coaching skills
- Inter-professional collaboration

Service development and organisational support:

- Knowledge of system within which NFP is delivered
- Understanding of implementation science as relates to NFP
- Credibility and authority with local implementing agencies and leaders
- Appreciation of Organisational development and system change theories
- Understands continuous quality improvement

[4] See also the Guidance Document 'Clinical Leadership for NFP'

- Interagency collaboration

Research:

- Credibility with research community
- Evidence base for NFP
- Qualitative and quantitative research design and methods
- Data analysis and reporting
- Commissioning research and data systems
- Communicating with nurses and supervisors

Policy and strategic leadership:

- Understanding national policy development and its implementation into communities
- Credibility and authority with policy leaders in government and national stakeholders
- Strategic leadership
- Communication and marketing skills
- Organisational management
- Business planning
- Entrepreneurial

ANNEX 1: FOUR STANDARD PHASES OF RESEARCH AND IMPLEMENTATION

Phase One – Adaptation. Phase One examines the adaptations needed to deliver the NFP program in local contexts while ensuring fidelity to the NFP model. Each new country is assigned a designated international NFP consultant (IC) who supports the designated implementing entity in identifying: program goals; how the NFP program will be delivered in the context of the country's health and social service systems; the population to be served; potential referral pathways; and organization of community support. The IC supports the implementing entity to develop a project plan for initial implementation and feasibility and acceptability testing. Guidance is also provided regarding recruitment of a Clinical Lead, adaptation of the Visit-to-Visit Guidelines, the supervisor and nurse education curricula and materials, nursing assessment/data collection forms, and other program tools/resources. The IC (and other PRC staff as needed) will deliver the initial NFP nurse education with the goal of countries becoming self-sufficient over time. The IC also facilitates connections with Clinical Leads in other countries implementing NFP, and access to other international NFP resources. Dr. Olds and other PRC staff will consult regarding the pilot study design, data collection tools, and evaluation procedures.

Phase Two – Feasibility and Acceptability through Pilot Testing and Evaluation. Phase Two involves conducting a pilot test of the adapted NFP program with the projected number of sites and/or clients specified in the licensing agreement. The pilot includes testing the feasibility of referral pathways, data collection measures/sources, program materials, nurse recruitment, nurse education, and any other relevant measures. The pilot will determine acceptability of the program for the mothers, families, community partners, nurses, implementing agencies, and any other relevant partners. The results of this work will inform what additional adaptations may be needed to ensure the feasibility and acceptability of the NFP program within local contexts. At the end of this phase, the country develops its NFP information system or adapts its existing system to accommodate NFP data requirements. Continued recruitment of clients in existing pilot sites, or expansion to further sites for continued learning regarding required adaptations, may be approved if requested. Countries will begin submitting annual reports on their program implementation progress during this phase. These annual reports are reviewed and discussed with Professor Olds and the IC.

Phase Three – Randomized Controlled Trial (RCT). This phase is established to estimate program effects on outcomes of clear public health importance that align with the outcome domains in the original US trials and that address additional goals of that country. This work is designed to determine the added value of the program for the populations and contexts in which it is being delivered. The expected research methodology is a Randomized Clinical Trial (RCT) as this provides the strongest evidence of program impact. In some circumstances, it may not be feasible or appropriate to undertake an RCT (e.g. where the population size is too small to estimate benefits reliably or where there are serious cultural concerns). In these circumstances, consideration will be given to use of other quasi-experimental designs. These studies are conducted independently from the PRC. However, Professor Olds (or his delegate) will consult on study design, sample size, recruitment and randomization methods, outcome measures, and planned data analysis as required. Selection of objective outcome measures and management of compensatory equalization within communities are critical issues involved in study planning. Countries are encouraged to conduct complementary qualitative studies, which can be helpful in understanding results of the RCT. The

PRC also facilitates consultation with other international NFP researchers when requested. During this phase, the implementing entity may seek approval to continue recruitment of clients in existing pilot and/or RCT sites until analysis and reporting of the RCT data are complete. Countries are expected to continue completing annual reports during this phase.

Phase Four - Continued Refinement and Expansion. Once the evaluation of the RCT has been completed and outcomes found to be of public health significance, the license holder and implementing agency will be in a position to further refine and expand the adapted NFP program in their country. This phase includes building capacity and establishing sustainable systems for funding; embedding clinical leadership; selecting and developing new sites; recruiting and educating new NFP nurses and supervisors; and continuously improving program implementation, including refinement and use of the NFP information system. It is expected that countries will move to a higher level of self-sufficiency during this phase while continuing to meet licensing requirements through the annual review process, including completing an annual report. This annual process provides an assessment of program fidelity, achievement of program benchmarks, and plans for improving performance. It is expected that countries will still receive support from the IC, although the frequency of this consultation will be reduced and follow a mutually-agreed schedule. Any substantive change in the way NFP is implemented will continue to require approval of the PRC.

References:

[i] Halle T, Metz A, Martinez-Beck I Eds. (2013) Applying Implementation Science in Early Childhood Programs and Systems Baltimore: Brookes

[ii] Fixen, Blase, Timbers and Wolf (2001) In search of program implementation:792 replications of the Teaching-Family Model. In G.A. Bernfield, D.P. Farringdon & A.W Leschield (Eds)' *Offender rehabilitation in practice: Implementation and evaluating effective programs* (pp. 149-166), London, England: Wiley

[iii] Metz, Halle, Bartley and Blasberg (2013) The key components of successful implementation. In Halle T, Metz A, Martinez-Beck I (Eds.)*Applying Implementation Science in Early Childhood Programs and Systems* Baltimore: Brookes

[iv] Hill P. and Olds D. Improving implementation of the Nurse-Family Partnership in the process of going to scale. In Halle T, Metz A, Martinez-Beck I (Eds.)*Applying Implementation Science in Early Childhood Programs and Systems* Baltimore: Brookes

